Knowledge Sharing Meetings
Family Planning and Reproductive Health Within Health Sector Reform Programs

Office of Population and Reproductive Health
Bureau for Global Health
U.S. Agency for International Development

Knowledge Sharing Meeting #1
Family Planning and Reproductive Health within Health Sector Reform Programs
September 9, 2002 Meeting Notes

USAID's Office of Population and Reproductive Health is in the process of developing a new service delivery strategy. A consultation process is underway with important stakeholders including Cooperating Agencies (CAs), USAID field missions, and other donors to examine key issues facing family planning and reproductive health in the coming decade. As part of this consultation process, a series of "knowledge sharing" meetings are being held to explore the strategic and technical issues that should be an important element of the new strategy. The first of these knowledge sharing meetings was held on September 9th.

The three-hour discussion session was aimed at sharing lessons learned to date on how USAID and its partners can engage in policy reform programs in ways that enhance family planning and reproductive health service delivery. Participants were provided with an excellent background paper by Tom Merrick of the World Bank entitled "Reproductive Health and Health Reform: Challenges and Opportunities" and a set of discussion questions to think about prior to the meeting. The discussion at the meeting was divided into two sections. The first dealt with a review issues surrounding health reform, SWAps and poverty alleviation strategies and the second, a look at decentralization and integration of services and the challenges that these reforms pose for programs.

Tania Dmytraczenko from the PHRplus Project provided a brief, thought-provoking presentation defining the issues and launching the discussion. The following are some of the key points emerging from the discussion.

- Health sector reform is a relatively young process. There is little hard evidence to date to demonstrate its successes. Many mistakes have been made in the process of learning what works. Collecting data on health program changes resulting from reform is a very important area that needs more attention and one in which USAID could make a major contribution.
- The issue of country readiness and capacity to implement health reform has been a major problem. The complexity and difficulty of the process has been seriously under-estimated by donors. Changing political leadership in countries (e.g. Zambia) has sometimes greatly complicated reform.
- SWAps provide an opportunity for donors to coordinate their activities at the country level. They may, but do not necessarily, include pooled funding arrangements. The most important part of SWAps is the coordinate planning and monitoring process in which USAID can be an important partner.

- USAID is venturing into pooled funding arrangements as evidenced by the Millennium Challenge, the Global Fund for HIV/AIDS, TB and Malaria and smaller efforts such as the Nepal Initiative for AIDS. This has not been a feature of most bilateral health programs due to legislative restrictions and the project-based programming process within USAID.
- The lack of adequate procurement capacity at the country level has been one of the most difficult problems to overcome but it is an area where USAID has much to offer. The emphasis, however, needs to be on developing and institutionalizing the host country's procurement systems.
- The mechanisms for financial flow is another important area in the reform process. National health accounts help to understand funding flows but they tend to be too aggregate. More detail is needed to track expenditures for specialized areas such as family planning and reproductive health.
- USAID can make a significant contribution to the reform process by using tools such as the DHS (with the Gwatkin poverty quintile index) to map service utilization, track those who do and don't benefit from reform and determine whether the poor are being reached. Modifications are needed, however, to be able to track changes at the district level rather than just at the national level.
- The lack of a shared vocabulary and vision about poverty alleviation is an isolating factor for USAID in relation to other international donors. Given that the USG has signed on to the Millennium goals, USAID needs to move forward with more explicit policy guidance relative to its position on poverty. This will facilitate USAID's early involvement in PRSP's and other sector reform work at the country level.
- USAID health officers and their CA counterparts need technical information and training in the area of health reform to enable them to become full partners in the process. Global Health needs to find a way to convey technical information in ways that can be readily used by field personnel and support their efforts once they are at the table with other donors on health reform.
- USAID's stovepiped way of dealing with strategic objectives and the fixation on demonstrating program results rapidly has been at odds with the more integrated approach of health reform, which places emphasis on capacity development and sustained change in systems. Both approaches are needed and must be balanced, based on country-specific conditions.

The second part of the discussion was launched by Karen Hardee of the Policy Project with a thoughtful overview of the issues surrounding decentralization. The following were the key points made during the subsequent discussion:

- At the country level, there needs to be more analytic work to determine the processes and functions that should be decentralized and those which should remain centralized for reasons of efficiency or economies of scale. There is no standard recipe for all countries.
- Defining the role and responsibilities of the central Ministry of Health is just as important as defining the role of the peripheral units.

- Decentralization has been most successful where there was considerable attention to capacity development. The experience with District Action Plans in UP state in India is an example of how existing local capacity of NGOs and government units has been utilized to support and accelerate decentralized family planning and reproductive health programs.
- Community involvement and generating the demand for services at the client level are key issues in facilitating and strengthening decentralization.
- Iran is an example of a decentralization success story.
- Decentralization and integration go together. Defining the essential service package is a good organizing principle for decentralization.
- Building capacity for decentralized management of integrated programs requires a multi-sectoral approach. CAs are restricted by the type of money they receive and find it difficult to work in an integrated fashion given the restrictions.
- Scaling up decentralized programs, especially in the larger countries, poses serious challenges and taxes USAID's management capacity.
- There are important human resource issues that affect both health reform and decentralization. Many countries are experiencing huge problems with brain drain as health personnel move overseas for higher wages. There are also serious civil service and pay issues that pose systemic problems that most donors are reluctant to take on.
- There are certain public health issues, like HIV/AIDS, that are compelling national emergencies. These kinds of crises may warrant special, highly centrally-directed programs in the short run.

In summary, it is very clear that USAID and its partners cannot afford to be on the sidelines of health reform. USAID has much to offer by way of keeping the reform process focused on improving sustainable program outcomes that are, after all, the underlying rationale for reform. Helping USAID field missions who are on the front lines of this process at the country level, engage productively, and at an early stage, in health reform is an important part of Global Health's responsibility in family planning and reproductive health as well as the other PHN program areas. The new FP/RH service delivery strategy must take into consideration this important contextual reality in almost every country where USAID is present and provide for technical and strategic leadership, both to assist field missions and in coordinating with other donors at the global level.

Knowledge Sharing Meeting II
18 October 2002
Discussion Summary

Refocusing on Clinical Family Planning Services and Revitalizing IUD Use and Repositioning Vasectomy:

Dr. Mark Barone outlined the key issues for clinical family planning services:

- Major differences in service provision for short-term versus clinic-based methods
- The public sector provides most clinic-based services
- Sustained effort is critical for success
- Demonstrating impact requires adequate resources
- Country context is critical

He concluded with thoughts on reinvigorating clinical family planning:

- The public sector is critical
- Strengthen what is already working and do more
- Don't abandon the "tried and true"
- Seize missed opportunities – especially women who want to limit but are still using short-term methods
- Sustained improvements required ongoing and long-term attention and efforts

Dr. Matthew Tiedemann reviewed the issues to revitalize IUD use and reposition vasectomy. He suggested that each method is "excellent – yet neglected" He discussed a program in Kenya to revitalize IUD use. Regarding vasectomy he suggested improved performance of vasectomy requires providing male friendly services, community outreach and media campaigns. Because of the socio-cultural factors that affect the choice of vasectomy, a sustained approach to informing about the method is required.

Dr. Tiedemann concluded with some issues for both donors and family planning programs:

- More clinical services are needed
- Male involvement is essential
- Duel protect and condom use
- Continued attention to and support for research utilization
- Continued support for research to answer policy and service issues from the field

The discussion that followed included strategies to reinvigorate clinical family planning, as well as issues of provider and/or program bias toward clinical methods.

Strategies to reinvigorate clinical family planning:

Simply training providers on IUD insertion is not an effective answer. Continuation rates of IUDs are relatively long, but some providers are reticent about inserting IUDs because they do not provide this method very often. One idea is to position IUDs with sterilization in specialized centers to give these methods more focus. It is important to look at where the clients come from. If a provider only performs one insertion a year then the quality will not be as good.

Doctors and midwives generally feel most comfortable with IUD procedures but in some regions midwives not allowed to insert them. Perhaps changing standards is one way to address this.

In any effort to reinvigorate FP, it is important to understand current provider biases as well as determine if the commodity is available.

The public sector is critical for reaching the poor, but we also need to look at the private sector. There is a resource gap that the public sector cannot fill. Studies show that many clients can afford and indeed are willing to pay for health services. We need a shift in thinking about the private sector. If the public sector says they will provide free services, then there is no incentive for those who can afford to pay to do so. We need to look at ways of amortizing costs. Furthermore, the public sector is changing…we need to think of where it will be in 10 years.

It is important that we think creatively. What about voucher programs? One successful example of creative thinking is that of the geographical strengthening of clinical services in Kenya. Perhaps we could look at market segmentation or social marketing for IUDs – so much more can be done.

In addition to demand generation, promoting the contraceptive image is important. Programs need to educate people so they can understand the potential health benefits.

We must look at root cause of lack of use – are these systematic causes or other?

As we look to reinvigorate FP, we should also keep in mind some of the technological changes that are taking place in this regard. We also need to think about contraceptive image and what can be done to ensure a positive image.

Finally, we need to consider the community perspective, particularly their definition of quality and quality methods/services.

Provider Bias

Provider bias is an issue that needs to be taken into account. What strategies can be employed to overcome this?

Some countries have larger program biases – not just limited to individual providers. In some cases, monitoring indicators can encourage a particular focus. Perhaps we could employ different monitoring methods or rewards for providers providing expanded choices and counseling. Many providers cannot

get reimbursed for counseling without providing a service so there is little incentive for them to provide counseling.

Often it is not just a provider, but an entire facility or site that promotes a certain bias. Sometimes even when providers are trained, clients are still unable to receive services because the providers are not there.

IUDs require more demand generation. There exists a demand for sterilization – perhaps these two can be linked.

One strategy is to look at the positive deviants. Look at those cases where we "know what to do." Issues regarding resources still remain, but successful systems have been created. Despite great differences from country to country, we can learn a lot from successes in places where we have already "graduated."

Many clients choose services that their friends/neighbors have had done, thus neighbors serve as promoters. One method becomes the norm. On the reverse side, if an individual is dissatisfied with a particular service, the individual will share that with his/her neighbors. It is important to encourage "friendly" clinical sites so that clients have a positive experience.

Vasectomies

We need to explore linking vasectomies with other male reproductive health issues. Our focus may be too narrow. Key to promoting reproductive health among men is understanding what are their priority health issues. What do they need/care about? Some programs have taken this approach and found that largely men's health concerns are associated with sexual function, STIs, or dental care. However, this may be region specific

We must think outside of the box in regards to promoting men's reproductive health including vasectomies. Perhaps working with the military, large companies, or using male outreach workers. It is important to focus promotional campaigns.

Experience has shown that men who desire vasectomies have generally participated in RH for their partner before. Additionally, most of these men have previously talked to other men who have had the procedure. Ethiopia is an example where "male champions" of vasectomies have been very effective in encouraging other men to have the procedure performed. Of great concern is what will it be like after the vasectomy is performed. Sexual dysfunction is a major concern. Yet, there exists no good provider reference for this. Something needs to be developed.

The approach towards men and reproductive health must be different than that of women. Even in clinics, men must be counseled differently. One hindering factor is that some providers are not comfortable working with men.

It is important to look at why men are coming to the clinics and how that relates to reproductive health. Are they coming for TB, STDs, VCT, or HIV? How does it relate to FP methods?

Postpartum is one of the most neglected areas, and could be added as an option. Vasectomy in post-abortion care has been effective in Turkey. Postpartum FP is usually either in the form of IUDs or sterilization. But it is generally pediatricians rather than reproductive health providers that have interactions with families postpartum.

Antenatal care is also a time when FP counseling can be effective. This way, by delivery it is not a new topic and a decision to use a FP method may have already been made.

Not only must we look at IUDs and sterilization, but also at Depo and Norplant. Furthermore, we must consider the needs of unmarried women and adolescent girls. This group is under-served and has a great deal of misinformation. Some national programs are reluctant to address this group, as are providers in clinics. Overall, we should look at pockets of unmet need.

To what extent is IUD being used in immediate post-abortion care? This depends. Some medical barriers exist, as providers are worried about the risk of infection. India's national guidelines state that IUDs should not be used in post-abortion care.

Rates of unmarried girls becoming pregnant post-abortion are twice as high as that of other women. Some estimates say 80 percent of these girls are pregnant again within two years. This underscores the importance of reaching adolescents with clinical methods.

These can be politically sensitive topics (for example, FP in Muslim countries), but we must determine our main goal - to provide quality healthcare choices. The local environment must determine the specifics of what is available. It must be "their" program (decided upon by the community) not USAID's. Iran is an example of a very successful vasectomy program. Voluntarism must be emphasized.

Vasectomy repositioning in FP – clinics must provide good male healthcare services, but there must also be good outreach programs associated with this.

There have been successful pilot programs, but then we must determine how to effectively scale up. Iran and Mexico have done so successfully. We need to look at countries that have had successful programs in the past and determine why they have changed.

Knowledge Sharing Meeting III
John Ross and John Stover Presentation
24 October 2002

The overall trends discussed by John Ross and John Stover focus around the fact that funding for population activities is not increasing (and in relative terms may even be declining) over the years while the need for population activities is increasing. Accordingly, we must somehow devise a way to meet the increased demand on more limited resources. The Ross/Stover presentation covered the following points:

- USAID activities expanded in number of countries
- Population growth affects the demand
- We must look at variables including method mix and new technologies, source of supply, access to services, integration of services and quality improvements, and effects of health sector reforms
- There is increasing demand for integration both in terms of reproductive health services as well as with other health services
- Population assistance is affected by
  - international funding
  - infrastructure changes
  - relations of donors and cooperating agencies
  - affects of HIV/AIDS on funding
- With plateauing assistance and increasing demand, we face a resource crunch
- What strategies will we employ to deal with the resource constraints?

Highlights of Group Discussion:

Method Mix – We need not only quality, but also availability. There was some discussion on how method mix may not always affect fertility rates – there are other factors that need to be considered that serve as barriers or influence choices. Some methods are more expensive than others. How important is it to have a large method mix available? Perhaps we could focus on certain methods.

Integration – This is an issue particularly as countries move towards self-sufficiency. Development assistance is not keeping up with the increase in population and inflation.

Population Funding – Not decreasing per se, but the real dollar amounts end up being less. Population funding is not necessarily being negatively affected by HIV/AIDS funding. But because of population growth, greater demand, and inflation the investment does not go as far. It may be necessary to focus on fewer countries because of funding constraints.

Implications – The revolution in service delivery is one that needs to take place in the most complex settings – countries in conflict or post-conflict situations. We need to determine if there are common strategies we can employ in all of these countries, or if we need to program differently for each case. These are very sensitive cases and we know very little about programming in these situations.

Urbanization – Urbanization is on the rise, which does pose some advantages for service delivery as well as challenges. The private sector works better in an urban environment. Healthcare professionals are generally better trained and work with a larger number of patients, which can lead to better quality. Population growth is taking place not so much in the mega-cities, but in the tertiary and secondary cities.

Strategic Approach – Given the resource constraints and issues discussed, it is necessary for us to develop a strategy in approaching these issues. One important issue to take into consideration is how countries that have had successful programs manage their resources once the donors withdraw. We must also consider what will happen to the fertility levels. Can these be sustained? There is a different set of issues for each country and group. We must also consider how to divide them (regionally or by other characteristics) as categorizing is helpful when developing a strategy.

With funding, we need to decide if it is better to focus on fewer numbers of countries or just continue business as usual in a more diluted manner.

There is potential for combining Family Planning with Maternal Health in countries that have made little progress or are just beginning in regards to fertility rates - there are useful linkages that can be made between the two. However, Maternal Health needs a much more extensive infrastructure to be effective and FP should not wait for that infrastructure to begin in an area. Family planning is much easier to implement with strategies such as social marketing or CBD programs.

Another area we need to look at is the private versus public sector. There are a number of users using public sector programs that can pay for their services. Perhaps we should think differently in countries that have made little or no progress in fertility rates by strongly investing in the private sector from the beginning. We can package simple interventions and get them out, but urban/rural barriers need to be considered.

We can look at increasing our efficiency, but that won't completely address the problem because we have already been trying to achieve greater levels of efficiency.

We do need flexibility in programming, but somewhere along the line we simply have to make some difficult decisions with constrained resources in determining our investment.

The commodity issue itself is part of resource constraints. There is an increased commodity demand, but funding parallels that of service funding. We need to look at where we are spending our money (technical assistance, commodities, infrastructure) and determine where our advantage is. Where is the best bang for our buck?

HPIC/debt relief – can lead to a great investment in healthcare on the part of national governments by freeing up resources.

We should not give up our efforts to increase funding just because HIV/AIDS has received so much attention and funding. There are lessons to be learned from the HIV/AIDS campaign.

They generate a lot of press and support. We can also look to other sectors (agriculture, transportation, and education) as this affects all of them as well. It should be part of their equation.

Donor contributions will never keep up with the estimated increase in number of users. The private sector must play a large role. How can we start engaging the private sector earlier in the countries with high TFR? Do we have to think always of supply-side assistance? How about focusing on training and standards and employing a voucher system to jump-start the private sector? Projects such as this have been tried in Haiti and Mali – and stopped. They were not very successful. This is something we should think through especially when thinking of countries such as Afghanistan. These are very complex settings so we don't know much about how such a strategy will work. The governments are unsteady and uncertain which makes the growth of the private sector difficult. The private sector needs a certain type of policy environment to operate effectively. How do you create this kind of a policy environment?

We need to be clear in our definition of service delivery. We also need to better define "we". We are not talking about Global Health alone – we must also consider the regional bureaus, etc. As we are looking at the entire budget, we must influence from the top.

Increasing funding for FP is slim chance. We must look creatively at what can be done given our resource constraints.

The private sector is very important but we must also recognize the costs – subsidies, marketing of programs. It is not an easy answer, but remains a very important strategy especially when considering sustainability issues. We owe it to ourselves to look at social marketing critically – the DFID paper claims it is 6 times as expensive.

We need to be clear on what our bottom line is – what are we trying to achieve? Is our goal to continue maximizing users? Regardless of the cost? Our ultimate goal will affect how many strategy options we have. If we are looking only to maximize users, we do not have a lot of latitude in changing the status quo.

There are differing TFR levels and needs. It is worth comparing the differences in where countries are going and what kind of assistance they need (whether that be technical assistance, commodities, etc).

Knowledge Sharing Meeting IV
Training
5 November 2002

Highlights from Rick Sullivan's presentation on pre-service education and inservice training:

- It can be institutionalized and sustained (included in line-item budgets)
- It can have a national impact
- It is a relatively cost-effective measure
- Both faculty and stakeholders must be involved
- In-service and pre-service training must be balanced and carried out concurrently

Discussion on pre-service training: The discussion focused around the question of whether or not missions are under-investing in pre- and in-service training and, if so, why.

One important perception is that pre-service training activities do not have an immediate impact on service delivery. When developing a pre-service curriculum, we must work with the Ministry of Health, and sometimes even the Ministry of Education. We must make a long-term commitment in our relation with these ministries in order to change curricula.

Choosing one type of training over another should be determined by what skills are needed. Mission buy-in to training depends on the objective of the mission. If pre-service and in-service education are part of their objectives, then they will invest. Missions make their own objectives. But the USAID system focuses on short-term results and this can negatively influence decisions particularly regarding investment in pre-service training. We need to step back from the short-term results to see the larger picture and focus on the longer term.

Revised curricula are indeed a result, though perhaps not an impact result. We need to articulate our case better when reporting results to show that things are actually taking place. There are many issues with trying to document the long-term impacts. We reap "soft" benefits like more positive interactions between providers and their clients. What is a fair measurement of results?

What is the follow-on demand with a revised curriculum? When one curriculum is successfully revised and applied do missions desire to revise other curricula?

In-service training focuses on skill. Pre-service needs more coordination around content areas among various agencies (USAID, WHO, etc.). Skills are transferable – if you teach nurses skills in FP, they can try to change the curriculum in other areas of healthcare.

There was some discussion about the specificity of training providers receive. Some sites require specific skill sets - separate clinics for STI's labor/delivery, etc. But many sites require general skill sets. It depends on where the providers are deployed.

Tensions in short-term results exist. We assume that investments in pre-service training will bear long-term results. But we must question if we are training the right people and in the right subjects. Will they still be around as active providers in a few years? We need better documentation of what happens to the students that are trained. Do they continue on to provide services?

We can legitimize skills by putting them in the curriculum. For many students there is no interest in particular skills until it is made part of the licensing requirements. One of the keys to effective pre-service training is the human resource element in recruiting the right people.

Perhaps we are underselling training to the missions by not claiming credit for what we are doing. We must present our results in a fashion that they can understand -- we are making important changes. We are creating "systems change" and down the line we will see other results. While many of our results are long-term, we must start claiming our successes in the interim.

There was much discussion about the possibility of Core money funding training since missions seem to be reluctant to invest in this. Lack of mission buy-in to training does not mean that they are not convinced of the importance. The reality is that they have overall funding constraints and training is a big investment.

Perhaps we are looking at the issues too narrowly. Maybe we need to take more of a multi-sectoral approach. If we look at pre-service too narrowly, it will not have much impact. We must look at it broadly. The reality is that people want to see results and missions feel that they must report out on annual results. But we can look at intermediate results and report on those.

Scaling up is also a big issue, especially in the larger countries.

We must determine how to balance between in-service and pre-service training. Nurses often end up in a facility and do not know how to run it because there was no management training in their curriculum.

Institutional change is a management issue that requires a great deal of time and energy. It may seem overwhelming at times. Most countries do not have national in-service training. What are we moving towards? It is better to have more pre-service training that result in less need for in-service training (the more costly of the two).

UN agencies are quite in favor of pre-service training. This is an important opportunity for partnering with other agencies. USAID should offer its expertise in a partnership with other agencies like the World Bank. Different bodies are able to do training and certification for continued licensure.

Both pre-service and in-service training and materials must be continually revised to remain updated. What kind of investment will that take? Faculty rely on the organization to provide materials. We must take good content to both the faculty and the students. Thus there will always be a need for international agencies to provide updated materials, etc. How do sustainability issues play into this?

Some limitations arise in the form of standardization across countries. It is difficult to find common standards even within one country, let alone internationally. We need to develop standards and guidelines that can be adapted for each country. We do not need to start from ground zero with each country, but there must be room for adaptation and ownership. We must involve faculty and key stakeholders in this process. But this is challenging in that each country is at a different point and it is difficult to determine a common standard of quality.

Another challenge is determining who is being recruited. Some students do not have the educational background necessary to tackle a standardized curriculum. How far back into the realm of education do we step? In some areas providers are paid very little and therefore do not even try to attract many clients.

For the future we should be looking at shifting to broader, more encompassing programs. Integration with other offices is very important, as there is a demand for training in a broad sense – not just limited to

FP. We need both breadth and depth and we must determine how to achieve this. It is difficult for individual CAs to manage projects with great breadth.

Highlights from presentation by Wally Hannum and Bea Bezmalinovic on On-the-job Training and Distance Learning:

- On-the-job (OJT) training must be planned and structured
- OJT must focus on the learner
- OJT and distance learning (DL) must be supported through incentives
- OJT is not meant to substitute for group-based training and can be linked with classroom training
- Learner support is critical in DL
- DL provides opportunity to practice new skills, reduces isolation, and links with others individuals
- Quality content is key
- We should look at how technology can help us achieve our objectives rather than using technology simply because it is available
- Blended learning approaches are most effective

Discussion on On-the-Job Training and Distance Learning:

There was discussion on the cost of investments of setting up e-learning sites. Computer access to technology is essential for any of these programs to work. The World Bank has invested quite a bit of technology (computers) in some countries, but the problem remains that many of the individuals are not trained on how to use the data. It would be beneficial to use leveraging strategies – let other agencies (like the World Bank) set up the computers and then USAID can use their expertise to teach people how to use the data sets.

New and improved content is key. There must be blended approach to learning using some technology based programs and other more traditional training as well. Some use e-learning only for reinforcement. The content is critical and must be appropriate – this is where our expertise lies. We must look at pedagogy and determine the best mix of training approaches for the learners.

Training is usually group-based whereas e-learning is more of an individual experience. What are the motivations for using technology? Just because we have the capabilities does not mean that they are effective and that we should use them. While individualized tools can be very effective, we must select the right combination to meet the needs of the learners.

Issues of support and supervision still exist. Do we see technology as a means of communication or a way to distribute materials? One example brought up was how the US military connects retired military personnel with less-experienced officers to provide counseling and mentoring. This has been very effective.

We must address the access gap, but the idea that "if we build it, they will come" is unrealistic. It will take much more than that to make it an effective program. We must identify and target those areas that are useful. Furthermore, ensuring access requires initial and continued investment.

We assume that the learners have a willingness to be trained, but we must also consider those who are passive about their approach to learning. Sometimes this can be overcome through a skilled facilitator. But overcoming this in individualized learning is much more difficult. Issue of learner support is key. If there is no ultimate accountability then we run into problems. We need to disentangle supervisors and

supervision. Coaching, encouragement, and learning support do not have to be facilitated by a supervisor. This can be done through peers as well.

We must consider where institutions will be in a few years from now. It is likely that most will have access to technology. One challenge we must face is how will we develop appropriate courses to standardize training and work with changing environments.

It is important for us to expand the team of learners. Site based and on-the-job training for teams is important. In terms of technological access we must look at where we want to be in five years, and how we will get there. We must start now to stay ahead of the curve. We can start testing these projects in areas like Latin America where there is greater access to computers.

We must consider what kind of content we can leverage across contexts. A "one size fits all" approach will not work, though a general base that can be adapted is important. Our investments must be carefully planned. But we do need to try to foresee the market and be prepared.

Technology itself will not improve the quality of instruction. Some on-the-job aids could help to reduce the need for training. But these need to be *good* job aids that are linked to job expectations. Job aids need to be adapted, not just translated for the various contexts. Training has largely become "mystified." We must look at how we can expand training methods and maintain both the real and perceived value.